Open Heart Kitchen
Dublin Senior Center

Please complete this form to the best of your ability.
Items Marked with asterisk (*) are required.

***Unique Participant ID**:_____
Referred by:_____
Intake Date: _____
Staff: _____
Beginning Date: _____
***Termination Date:** _____
***Reason**:_____

Eligibility:
☐ Age 60+
☐ Spouse of ENP Participant
☐ Disabled person residing where the congregate site is located
☐ Disabled person who resides with and accompanies an ENP participant
☐ Volunteer

Last 4 Digits Social Security # *Optional* | | | | |

First Name:	Last Name	***Date of Birth**: / /
Home Address:	City:	*Zip Code:
Mailing Address: Same As Residential? ☐ Yes	City:	Zip Code:
Home Phone: ( ) Alternate Phone: ( )	Emergency Contact Name: Phone: ( ) Relationship:	

***Living Arrangement # of household members** ☐
☐ Declined to State

***What is your approximate household income?**
$_____ per ☐ month ☐ year ☐ Declined to State

***Rural Area?**
☐ Yes ☐ No
☐ Declined to State

***Gender:** (Check One)
☐ Male ☐ Declined to State
☐ Female

***Ethnicity** (Check One)
Hispanic ☐ Yes ☐ No
☐ Declined to State

Language:
☐ English speaking ☐ Need interpreter
☐ Non-English/Language:

***Race**: (Check One) ☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese
☐ Other Asian ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Multiple Race ☐ Other Race ☐ Declined to State

***Nutritional Assessment:**	**No**	**Yes**
Have you made any changes in lifelong eating habits because of health problems?	0	2
Do you eat fewer than 2 meals per day?	0	3
Do you eat fewer than 5 servings (1/2 cup each) of fruits or vegetables every day?	0	1
Do you eat less than 2 servings of dairy products (such as milk, yogurt, or cheese) every day?	0	1
Do you have __biting, __chewing, or __swallowing problems that make it difficult to eat?	0	2
Do you sometimes not have enough money to buy food?	0	4
Do you eat alone most of the time?	0	1
Do you take 3 or more different prescribed or over-the-counter drugs per day (aspirin, herbs, laxatives, etc.)?	0	1
Without wanting to, have you lost or gained 10 pounds in the past 6 months?	0	2
Are you not always physically able to __shop, __cook, and/or __feed yourself (or to get someone to do it for you)?	0	2
Do you have 3 or more drinks of beer, liquor or wine almost every day?	0	2
☐ Declined to State (0-2: low risk; 3-5 moderate risk: 6 or more high risk) **Total Score Today:**		

I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that the Area Agency on Aging and service providers may use it to help identify other services for which may benefit.

_____ _____
Signature of participant or person completing the form Date